Effective Date: October 1, 2006
Revised Date: April 13, 2011

CRITERIA FOR PRIOR AUTHORIZATION

Insulin-Like Growth Factor

PROVIDER GROUP: Pharmacy

MANUAL GUIDELINES: The following drug(s) requires prior authorization:
Mecasermin (Increlex®)

CRITERIA: (Must meet all of the following)

- Diagnosis of growth failure due to severe primary insulin-like growth factor deficiency (IGFD) documented by all of the following:
  - Height standard deviation score ≤ -3.0
  - Basal IGF-1 standard deviation score ≤ -3.0
  - Normal or elevated growth hormone (GH) level

OR

- Diagnosis of growth hormone gene deletion with neutralizing antibodies to growth hormone (GH).

AND

- Must meet all of the following:
  - Thyroid and nutritional deficiencies must be corrected before initiating therapy.
  - Patient must be 2 years of age or older.
  - Patient must have open epiphyses.
  - Treatment must be prescribed and managed by an endocrinologist.

Note: Requests will be denied for use in patients with secondary forms of IGF-1 deficiency, such as GH deficiency, malnutrition, hypothyroidism, or chronic treatment with pharmacologic doses of anti-inflammatory steroids.

Prior Authorization will be approved for six (6) months.

Renewals will be evaluated for approval based on documented improvement per physician assessment.